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I am writing to share with you my concerns for my patients under the changes announced in the last Federal Budget to the Better Access Scheme. The changes represent a substantial cut in available sessions from 12 to 18 sessions under the current arrangements, to 6 to 10 under the proposed changes. I fail to see how this is investing in mental health and will have a significant and negative impact on my patients. I thank the Senate for holding this important inquiry and for the opportunity to make this submission.

I am a Clinical Psychologist in full-time private practice. My area of specialty is in treating adult survivors of childhood trauma including conditions such as Borderline Personality Disorder (BPD). BPD is a serious, severe and chronic condition which is often accompanied by self-harm and suicidal behaviours. For these patients the current 18-session limit is barely adequate. These patients are often referred to me by the public mental health system which is unable to meet their needs for psychological treatment. For example, I provide the patient's psychotherapy while they are medically managed at their local Community Mental Health Centre. In some locations effective treatments are offered for small numbers of these patients within the public system – for example, the Dialectical Behaviour Therapy Service at The Alfred Hospital, here in Melbourne. This service can stabilise the patient so they are no longer so actively suicidal. After completing this program these patients are then referred on to Clinical Psychologists such as myself to complete their treatment.

Unfortunately, under the budget changes this will no longer be possible. I believe it will not be possible to adequately treat these patients in 6 to 10 sessions per calendar year. Evidence-based and effective treatments are available for these patients, as well as other serious mental illnesses. Clinical Psychologists have the necessary training and expertise to provide this treatment. In order to provide this treatment I need to be able to see the patient more often than the proposed less than once per month; weekly sessions are in fact required. It is accepted in the Medicare Schedule that this patient group has special needs and they are able to see a Psychiatrist more often than a patient without these diagnoses. This recognition should be extended to Clinical Psychologists as well, not reducing access to effective treatments for this very unwell group of patients.

Unfortunately there are not enough Psychiatrists with the necessary training and willingness to treat this patient group. The out-of-pocket cost is usually prohibitive for the patient. It is also worth noting that many of my patients in this group have been referred to me by their Psychiatrist, in the acknowledgement that the patient needs effective psychotherapy which they are not necessarily trained to provide.

I thought an example of how this will affect a patient of mine may be helpful. I have been treating a young man in his 30's with a diagnosis of Bipolar Affective Disorder with co-morbid drug and alcohol abuse and complicating personality factors. He was referred to me by his Psychiatrist. He receives the Disability Support Pension as he is unable to work. Under the current arrangements, he is able to be seen every fortnight and somehow he manages to find the money to pay for a few extra sessions, at a reduced rate, at the end of each calendar year when his 18 Medicare sessions run out. This has enabled a sound therapeutic relationship to be developed over the last two years and for him to respond to effective treatment. I am now in the very unpleasant position of having to explain to this man that the treatment that is working will no longer be available to him under Medicare. It is likely that without access to treatment this man would no longer be alive, he would have committed suicide.

Unfortunately I am also now in the position of considering no longer working with the patients I have been trained to treat. This appears to be a considerable waste of my training and experience. It could be considered unethical to accept a patient for treatment when they are unable to attend more often than less than once per month. Managing the risk of self-harm and suicide with these patients is a challenge in private practice, and many practitioners are not willing to take on these patients. This risk cannot be managed with 10 sessions per year. Nor can effective treatment be provided.

A person with a severe and complex mental illness requires and deserves to be able to access effective treatments regardless of their income. Indeed, patients with moderate illnesses, such as uncomplicated depression and anxiety, still require and deserve access to effective treatments. If this was a physical illness we would not be having this debate.

I am saddened to see this reduction of access to effective psychological treatments for the most disempowered in our society. Surely we can do better.

I look forward to a reconsideration of this change in the interests of my patients and the increasing proportion of the population who are suffering from mental illnesses.

Yours Sincerely

Jeffrey Kelly